INDIVIDUALIZED EMERGENCY PLAN

Name: _____ Date: _____/_____/____

_____

When a provider scheduled to provide support services does not arrive at my home; (homemaking, personal care, transportation, respite, or other)

1. Call the provider who is scheduled to come:

NAME:_____PHONE:_____

2. If the first provider is unable to come, call the back-up provider(s) until you reach someone:

NAME:_____PHONE:_____

NAME:_____PHONE:_____

NAME:_____PHONE:_____

3. Anytime you use your back-up plan, contact the Transition Team to let them know what happened and the resolution:

NAME:_____PHONE:_____

NAME:_____PHONE:_____

IMPORTANT NUMBERS

Providers: **Phone:**

(1) _____**Phone:**_____

(2) _____**Phone:**_____

(3) _____**Phone:**_____

(4) _____**Phone:**_____

(5) _____**Phone:**_____

Family:

(1)_____Phone:_____

(2)_____Phone:_____

(3)_____Phone:_____

(4)_____Phone:_____

Transition Team Members:_____Phone:_____

Physician_____Phone:_____

Physician_____Phone:_____

Pharmacy_____Phone:_____

EMERGENCY NUMBERS

Fire Department_____

Abuse Hotline_____

Ambulance_____

Police_____

Poison Control_____